NEW YORK STATE DEPARTMENT OF HEALTH
Office of Managed Care
Workers' Compensation Programs

Workers' Compensation
Preferred Provider Organization
(PPO) Application

Name of Applicant_____

Street Address_____

City, State, Zip_____

Telephone Number (Area Code)_____ **Fax (Area Code)**_____

Name of Executive Director of Proposed PPO_____

Telephone Number (Area Code)_____

Instructions:

The information requested in this application is based upon the provisions of Article 10-A of the New York State Workers' Compensation Law, Part 325-8 of Title 12 New York Codes, Rules and Regulations, and Part 732 of Title 10 New York Codes, Rules and Regulations. Copies of Article 10-A of the WCL and Part 325-8 of Title 12 NYCRR can be obtained from the Workers' Compensation Board at (518) 474-2686. Copies of Part 732 of Title 10 NYCRR can be obtained from the Department of Health at: (518) 474-5514.

A. Complete the application cover sheet and provide all narrative and documents as described in the ensuing sections. Number each narrative and document according to the item number to which it responds. Number each page in the upper right hand corner. Tabs should be inserted indicating each of the major sections of the application. Number all pages consecutively.

B. A non-refundable application fee in the form of a check or money order for **$500**, payable to the New York State Department of Health, is to accompany the application.

C. If the applicant is not domiciled in New York State, the application must include a copy of a proposed or existing certificate of doing business under an assumed name and/or a copy of the application for authority to do business in New York State.

D. Five copies of the Workers' Compensation Preferred Provider Organization Application must be submitted to:

N.Y.S. Department of Health
Workers' Compensation Programs
Corning Tower, Room 1919
Empire State Plaza
Albany, New York 12237-0062

Federal Employer Identification Number _____

Signature of Executive Director of Proposed PPO_____ **Date**_____

Signature of Board Chairman of Proposed PPO_____ **Date**_____

Signature and Title of Individual Executing PPO Application_____ **Date**_____

GENERAL INSTRUCTIONS: Respond to all questions, numbering all pages of the application, including attachments, in consecutive order. Submit all requested information identified by the Department in this application form.

I. ORGANIZATION AND MANAGEMENT

A. Organizational Structure

Describe in detail the organizational structure of the proposed PPO. An organizational chart should be included, with explanations of the lines of authority. Provide the following documents with any explanations necessary to clarify their meaning or use:

- articles of incorporation for the proposed PPO;
- bylaws for the proposed PPO; and
- any other legal documents relating to the proposed PPO.

B. Management

Identify the management staff, including the administrator and medical director as well as positions budgeted but not yet filled. Describe in detail the responsibilities of all key management staff, workload estimates and salaries.

Include all personal qualifying information requested for all management staff, each officer, director, partner or owner of the proposed PPO.

C. Financial Statement

Provide an independently audited financial statement of the current financial condition of the proposed PPO.

D. Location of Office(s)

Identify the location of the administrative office(s) including the address(s), space occupied.

II. GOVERNING BOARD

Describe the role and responsibilities of the governing authority of the proposed PPO.

Attach the bylaws of the governing board if the responsibilities of the governing board are not included in the bylaws of the corporation.

List the members of the governing board and include all personal qualifying information for each board member.

III. SERVICE AREA

Describe the service area for the PPO identifying the counties included in the proposed service area. Include a rationale for selection of this service area.

IV. SERVICE DELIVERY NETWORK

A. Provide a detailed description of the providers in the service delivery network including: the names, credentials, license numbers, Workers' Compensation Board authorization numbers, addresses, telephone numbers, sites of care, and, if applicable, a history of any professional misconduct.

Describe the basis for determining the adequacy of the provider network.

B. Workers Compensation Board (WCB) authorized providers that are required to be in the PPO provider network include:

family practice (board certified GP), orthopedic surgery, neurology, internal medicine, physical therapy, chiropractor, surgeon, anesthesiology, physical medicine and rehabilitation, psychiatry, psychology, radiology, dermatology, cardiology, pulmonary disease, ophthalmology, hand surgery, pathology, plastic surgery, urology, podiatrist, occupational therapy, neurological surgery, otolaryngology, thoracic surgeon, allergy and immunology.

C. Attach the following:

- copies of the proposed direct contracts to be executed with providers, hospitals, and ancillary service providers;
- a listing of all contracted providers by specialty for each county in the proposed service area;
- a table which summarizes the number of contracted providers by specialty for each county within the proposed service area;
- a listing of all contracted hospitals within the proposed service area and the Workers' Compensation Board District Office service area;
- a listing of all contracted ancillary services by county within the proposed service area;
- a map sufficiently detailed to accurately and completely indicate service area boundaries and identify the location of the provider sites. Provide a map key for identification purposes; and
- a sworn affidavit which attests to the fact that the PPO has contracted with WCB authorized providers and has developed an adequate provider network capable and willing to provide services pursuant to Article 10-A of the Workers' Compensation Law and Part 732 of Title 10 NYCRR.

V. SERVICE DELIVERY ACCESS AND PROTOCOLS

A. Describe how the PPO will ensure accessibility, availability, and continuity of care for the claimant including the protocols to ensure that emergency and urgent care is available and accessible twenty-four (24) hours a day, seven (7) days a week; that all non-emergency care is available within forty-eight (48) hours and that subsequent referrals are timely; and the provisions for obtaining care outside the network in instances where the PPO cannot provide access to necessary services within forty-eight (48) hours.

B. Describe how medical records will be afforded confidentiality as required by Part 732-2.2(i).

C. Submit a copy of the proposed handbook. The handbook must include a description of the provider network and include all information defined in Part 732-2.6(e)(1-15).

VI. QUALITY ASSURANCE SYSTEM

A. Describe the quality assurance and improvement committee's procedures for the ongoing identification, evaluation, resolution, and follow-up of problems in health care administration and delivery to claimants, including:

- the accountability of the committee to the governing authority;
- supervision by the medical director;
- regularly scheduled meetings and written minutes of the meetings;
- participation of an appropriate base of individuals including the administrator, an employer representative, clinical personnel, including physicians and other health care providers;
- peer review;
- procedures for the analysis of high risk procedures;
- the methods for establishing standards to be utilized for quality assurance review; and
- a description of methods to be used for medical record audit, including sampling techniques.

B. The quality improvement activities must include the development and documentation of timely and appropriate recommendations for addressing problems as well as the steps taken to follow-up on recommendations made by the quality assurance/improvement committee. Quality improvement activities must also address the following:

- review and documentation of all complaints and reasons given by those who opt out;
- review and assessment of the continuity of care;
- review and assessment of the appropriateness and timeliness of referrals; and
- review of adequacy of access to care.

C. Describe the procedures and standards for recruitment and selectio of providers. Include a description of the procedures to be used for follow-up and ongoing monitoring of providers. Include a description of the orientation and training for physicians.

D. Describe the content and frequency of patient satisfaction surveys t be conducted.

E. Describe the safeguards to be used by the PPO in order to prevent utilization control from adversely affecting quality assurance in the PPO.

F. Describe how the PPO will maintain a return-to-work program in conjunction with the employer, treating physician and carrier to facilitate the return of the injured worker to the workplace.

VII. UTILIZATION CONTROL AND REVIEW SYSTEMS

Identify the utilization review mechanism and the licensing authority under which it operates (see Part 732-2.2(f)(1)(2)). Describe the utilization review process and the reports that are produced (e.g. physician profiling, outcome reviews, employer profiling); the frequency of review; the treatment standards used (cite source); and the types of corrective actions that will be taken in response to identified problems.

VIII. GRIEVANCE SYSTEM/DISPUTE RESOLUTION/SECOND MEDICAL OPINION

Describe the grievance system/dispute resolution process and the manner in which it ensures access to a second medical opinion, addresses disputes which arise between the PPO and the insurance carrier or between the PPO and the employer; and grievances and/or disputes which arise between the PPO and the claimant; a PPO provider and a claimant; the PPO provider and the insurance carrier; and/or the PPO and the provider.

IX. MANAGEMENT INFORMATION SYSTEM

Describe in detail the management information system including:

- sample formats generated by the PPO system; and
- a description of the system's capability to supply data for required reports such as utilization review and quality assurance studies.

X. ATTESTATIONS

A. Disclosure Attestation

The PPO shall submit a notarized attestation which states that the PPO will make available, upon request of a claimant, the following information:

- lists of names, addresses and positions of PPO board of directors, officers, controlling persons, owners or partners;
- financial statements of the PPO;
- information relating to consumer complaints compiled;
- procedures for protecting confidentiality of medical records and other patient information;
- a description of the organizational arrangements and procedures for the quality assurance program
- an individual health practitioner's affiliation with participating hospitals;
- written clinical review criteria relevant to specific conditions and diseases; and
- application procedures and minimum qualifications for providers to be considered by the PPO.

B. Financial Interest Attestation

The PPO shall submit a notarized attestation which states that the insurer or employer has no financial interest in the PPO.

XI. CONTRACTUAL ARRANGEMENTS

A. Provider Contracts

Submit, for review and approval, sample contracts for each provider type. All contracts shall address the following:

- the rights and responsibilities of each party including the responsibility to comply with all applicable laws, regulations, PPO policies and procedures and generally accepted standards of care as reflected in the PPO's quality and treatment standard protocols;
- the provider's responsibility to comply with Section 18(a) of the Public Health Law regarding disclosure of information to claimants;
- the rights of the PPO and the Commissioner to have access to review and obtain copies of medical and other records; and
- the providers responsibility to participate in and comply with peer review, utilization review, dispute resolution and quality assurance program requirements; to file required reports on a timely basis; and to provide testimony to the Workers' Compensation Board, as required.

B. Management Contracts

Submit, for review and approval, any management contract with an entity to oversee the management of the day to day activities of the PPO with respect to the performance of various services including: management information systems, utilization review, case management, quality assurance and medical dispute resolution .

(**Note:** A PPO may not enter into a management contract with a self-insured employer, an insurance carrier or with any entity owned or controlled by, or affiliated with such carrier to oversee the management of the day to day activities of the PPO with respect to the performance of quality assurance and medical dispute resolution).

All management contracts shall be developed in accordance with the provisions of Part 732-2.5(b)(1-6) of Title 10 NYCRR and Part 325-8 of Title 12 NYCRR.

C. Business Contracts

Any stock corporation, mutual corporation or reciprocal insurer authorized to transact the business of workers' compensation insurance in New York State, or self-insurer, may contract with a PPO to deliver all medical services mandated by the Workers' Compensation Law. All contracts shall be submitted to the Department for review and approval prior to execution.

XII. CHARACTER AND COMPETENCE REVIEW EXEMPTION

The PPO applicant is exempt from submitting personal qualifying information for individuals who have supplied such information to the Department of Health within the last five (5) years, and who as a result, were certified to participate in the administration and/or delivery of health care services within New York State.

Please contact the Department for copies of the PPO Character and Competence Review Forms.